Exhibit 2

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
CIVIL ACTION FILE NO. 1:23-CV-480

Planned Parenthood South Atlantic, et al.,

Plaintiffs,

vs.

JOSHUA STEIN, et al.,

Defendants,

and

PHILIP E. BERGER and TIMOTHY K. MOORE,

Intervenor-Defendants.

VIDEOTAPED DEPOSITION
OF
KATHERINE A. FARRIS, MD

TAKEN AT THE LAW OFFICES OF:
WARD AND SMITH, P.A.
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ASHEVILLE, NC 28801

09-01-2023
10:11 O'CLOCK A.M.

Laura Baker
Court Reporter
for Cape Fear Court Reporting, Inc.
PO Box 10112
Wilmington NC 28404

2023, you would agree that PPSAT North Carolina was performing surgical abortions on patients in their 13th week and later gestational age and charging money to perform those abortions, right?

A. Prior to July 1st, Planned Parenthood South Atlantic was performing procedural abortions beyond the 12th week of pregnancy and charging for those abortions, yes.

Q. And this law, this change in the law, has caused PPSAT to lose the income that it made from charging those patients for those abortions, right?

MS. SWANSON: Objection to form.

THE WITNESS: I am not aware of what our income balance is since the change in the law.

Q. (Mr. Boyle) Well, you're aware that if you were performing those abortions before and charging money and getting paid for them, and now you're not, you've lost that money, right?

MS. SWANSON: Objection to form.

THE WITNESS: I am not aware of what money or what our income has been since the change in the law.

Q. (Mr. Boyle) Yes, I'm not asking about your general income or your general balance sheet. I'm saying, the simple fact is, if you were doing those

abortions and charging money for them before, and now you no longer are, you've lost that money that you made before, correct?

MS. SWANSON: Objection to form.

THE WITNESS: I think that would require me to speculate, because we've changed the services we provide since the law went into effect, and I can't speculate as to the exact impact that has had on our income.

Q. (Mr. Boyle) I'm not asking you to compare income. I'm just asking if you simply lose revenue from that potential source if you're no longer doing it.

MS. SWANSON: Objection to form.

THE WITNESS: I can state that we are not charging for abortions that we are not performing, and we are not performing abortions, routinely, beyond the 12th week of pregnancy since the law went into effect.

Q. (Mr. Boyle) You just said, "routinely." Are you performing them at all?

A. Legally, we can perform them. And I'm not personally aware of an abortion that has done -- that has been done past the 12th week that meets one of the exceptions.

Q. So as I understand your testimony, you're saying that it's possible that an abortion after the 12th week that meets one of the exceptions under the new law has been performed at a PPSAT clinic since July 1st leading up to today, September 1st, but you're just not aware of that.

A. Correct.

Q. Okay. I just want to clarify. If you were making money doing that type of abortion before July 1st when the law in effect, and now you're no longer doing it, you would agree that you've lost at least that money that you were able to make and charge for those abortions that you're not able to make and charge now, correct?

MS. SWANSON: Objection to form.

THE WITNESS: I would not characterize that I -- that PPSAT has lost money. I would characterize that PPSAT is not charging for procedures that we are not performing.

Q. (Mr. Boyle) PPSAT is a nonprofit. Is that correct?

A. Yes, that's correct.

Q. Does it provide any charity care to patients?

MS. SWANSON: Objection to form.

THE WITNESS: I am not deeply involved

is just anterior to the uterus in most patients, although there can be a space, and often is a space, between the uterus and the bladder; and the intestines can be in the space generally surrounding the uterus.

Q. (Mr. Boyle) Any other organs that would be immediately adjacent to the uterus, if there was a uterine perforation?

A. Those are the organs that are closest to the uterus.

Q. You would agree that uterine perforation is a known complication of a surgical abortion, wouldn't you?

A. Uterine perforation is an extremely rare but known complication of procedural abortion.

Q. Have you ever had a patient who you performed a surgical abortion on who suffered from a uterine perforation?

A. I have had a patient that I performed a procedural abortion on who had a uterine perforation.

Q. Did you have to transfer the patients, who you performed a surgical abortion on who suffered a uterine perforation from the Planned Parenthood clinic, to the hospital?

A. No, I did not.

Q. You -- are you aware that sometimes, if a

patient has a uterine perforation during a surgical abortion, it's required that they be transferred to a hospital for higher level of care?

MS. SWANSON: Objection to form.

THE WITNESS: I am aware that there are some cases of uterine perforation where the patient does need to be transferred to a hospital for additional care.

Q. (Mr. Boyle) Has that ever happened at PPSAT?

A. Yes, it has.

Q. Did you know before the surgical abortion was performed that those patients who suffered a uterine perforation would require transfer to the hospital based on that known complication?

MS. SWANSON: Objection to form.

THE WITNESS: I just want to clarify. Are you asking if I knew in advance that a patient would experience a uterine perforation and require transfer?

Q. (Mr. Boyle) That is what I'm asking.

A. No, it is not possible to know that in advance.

Q. Because you can't always know what complications will arise during a surgical procedure, can you?

A. It is true that with any procedure, you cannot always predict accurately what complications may arise.

Q. What is a cervical laceration?

A. A cervical laceration is a tear of the cervix.

Q. You agree that a cervical laceration is a known complication of surgical abortion, don't you?

A. I would agree that a cervical laceration is an extremely rare but known complication of procedural abortion.

Q. Have you ever had a patient, who you performed a surgical abortion on, who suffered from a cervical laceration?

A. I would say that I have had a patient who suffered from some bleeding associated with the instruments we use on the cervix, but I've never had a cervical laceration that required interventions such as suturing.

Q. Do some patients who suffer the known complication of surgical laceration during a surgical abortion require transfer to a hospital for a higher level of care?

MS. SWANSON: Objection to form.

THE WITNESS: I'm not aware of patients

needing to be transferred for cervical laceration.

Q. (Mr. Boyle) Are you aware of any patient from PPSAT who suffered a cervical laceration during a surgical abortion having to be transferred to a hospital to care for that known complication?

A. I do not recall any patient with a cervical laceration having to be transferred for that complication.

Q. Have you ever had a situation where you performed a surgical abortion on a patient and the patient suffered hemorrhaging such that you needed to transfer that patient to a hospital for higher level of care?

A. I have had a patient who hemorrhaged during a procedural abortion who I transferred to the hospital for care, yes.

Q. Is hemorrhage a known complication of surgical abortion?

A. Hemorrhage is an extremely rare and known complication of procedural abortion.

Q. Are you aware of other patients from PPSAT who have suffered hemorrhage during a surgical abortion that were transferred to a hospital for a higher level of care?

A. I am aware of patients who have suffered

hemorrhage during a procedural abortion who have been transferred to a hospital.

Q. Did you know, before the surgical abortion was performed, that those patients who suffered hemorrhage that required transfer to the hospital would have that complication during that surgical abortion?

A. No. You cannot know in advance what complication a patient may experience from any given procedure.

Q. Do you disclose all possible complications that can arise from an induced abortion to a woman who has tested pregnant, who has tested positive for pregnancy, who is your patient considering obtaining an induced abortion?

A. We disclose the most common and most concerning potential complications to patients as part of their informed consent.

Q. And tell me, what -- how many days is the waiting period now, under the new law, SB20 and HB190, for informed consent for a patient seeking an induced abortion before the induced abortion can actually occur?

MS. SWANSON: Objection to form.

THE WITNESS: My understanding of the current law is that it requires a 72-hour waiting

period from the time the State consent form is reviewed by the patient and signed and when the abortion takes place.

MR. BOYLE: I'm going to hand you a document that has Bates numbers that was produced in discovery.

MS. SWANSON: Thank you.

Q. (Mr. Boyle) It's Bates Numbers 31 through 50. If you don't mind, down at the bottom right-hand corner, do you see Bates and then numbers there?

A. I do see those numbers, yes.

Q. And the first page says Bates 31. Do you see that?

A. I do see that, yes.

Q. And then if you turn to the last page, please, you see Bates 50?

A. Yes, I do see that.

Q. Okay. So do you recognize this document?

A. Yes, I do.

Q. What is it?

A. This is our education and consent packet for procedural abortion.

Q. Can a patient die from complication of bleeding if there is a cervical laceration or a uterine perforation or hemorrhage?

correct?

A. This is a signature page. We don't actually use paper forms for signature. We use an electronic health record, so we use an electronic version of this form, unless our electronic health system is down, and then we use the paper form. But the patient does sign an electronic version of this form, yes.

Q. Is the electronic version of this form exactly the same format as this paper copy here, this 34, 35 and 36?

MS. SWANSON: Objection to form.

THE WITNESS: I would -- I can't speak to the exact format, but it contains the same information. We use this form to create the electronic form.

Q. (Mr. Boyle) So you don't actually hand a patient this piece of paper, this three-page document. Is that what you're saying?

A. No, that is not what I'm saying. I do hand the patient this three-page document. We at Planned Parenthood hand the patient this document.

Q. Okay. So someone at -- at PPSAT hands the patient a three-page document that looks like Bates Number 34, 35 and 36, and that patient then has that hard copy paper document to take with them? Is that

correct?

A. It is correct that the patient receives a paper copy of this document before they leave the clinic -- or actually, when they are arriving and going through consent.

Q. Okay. Do the -- does the patient receive a signed copy of this document?

A. The patient does not routinely receive a copy of this form that they have signed, but they may receive a copy, if they would like, that can be printed from the EHR for them if they request it.

Q. So when the patient signs an electronic copy of this document, is the patient looking at a computer screen and having the opportunity to read all three pages before they sign, or do they have a paper copy? What's the method for that?

A. They have both. They have a paper copy in front of them, and they can see the electronic form as it is being filled out and they are signing it.

Q. And who goes over this document with the patient?

A. A trained staff member.

Q. What level of training does that staff member have?

MS. SWANSON: Objection to form.

THE WITNESS: They are -- they can have a variety of backgrounds of training, but they are specifically trained in the process of Planned Parenthood South Atlantic's informed consent.

Q. (Mr. Boyle) Is that person who undertakes informed consent with the patient, is that a nurse? Is that a PA? Is that an MD doctor? What level of training do they have?

A. It varies based on which aspect of informed consent you're referring to.

Q. Okay. How about this aspect with this three-page document? What level of PPSAT employee -- in terms of training for that employee, what level of employee is engaging with the patient to ensure informed consent is obtained?

A. It can be multiple levels. I've had nurses or physicians who participate in that. Routinely, it is not a licensed person who is going over the form. It is someone who is trained specifically in the process of consent who had -- goes over the form with the patient.

Q. Does the law speak to who has to interact with a patient, what level of training that person has, in order to ensure informed consent is indeed proper and legal?

MS. SWANSON: Objection to form.

THE WITNESS: So the second category I referred to, we call a probably intrauterine pregnancy. And I don't know how to answer the question, "Is there a different differential diagnosis?" I'm not really clear what you're asking.

Q. (Mr. Boyle) Is your differential diagnosis the same or different compared -- Category 1 to Category 2?

MS. SWANSON: Objection to form.

THE WITNESS: I would say it was different. One of the common ways we would see a probably intrauterine pregnancy would be in someone who had a large, empty uterine sac. And depending on the size of that sac, would make us either suspicious for, or clinically certain, that the patient was experiencing a miscarriage.

Q. (Mr. Boyle) Okay. How about for Category 3, which I believe you said was an ultrasound that definitely showed an ectopic pregnancy? What's your differential diagnosis for that patient?

MS. SWANSON: Objection to form.

THE WITNESS: I would consider that patient to have an ectopic pregnancy or a pregnancy outside the uterus.

Q. (Mr. Boyle) And what would you do as a result of that?

A. If I see a patient with an ectopic pregnancy, I refer them for treatment of that pregnancy.

Q. Refer them where?

A. Either to their primary gynecologist, if that's their preference, and they're able to see them quickly, or to a hospital for care.

Q. Because an ectopic pregnancy is a life-threatening risk for a patient, isn't it?

MS. SWANSON: Objection to form.

THE WITNESS: An ectopic pregnancy can be life threatening if not treated, yes.

Q. (Mr. Boyle) Because it's a pregnancy growing outside of the uterus, where it's supposed to be, and it can cause -- if it's in the fallopian tubes, it cause those to rupture and bleed, right?

A. That is one form of ectopic pregnancy. There are many locations that an ectopic pregnancy can exist, including technically within the uterus.

Q. Okay. And if you have -- well, the fourth category would be an ultrasound that showed a suspected ectopic pregnancy. How would your differential diagnosis for that fourth category differ, if any way, from the third category, where you actually identified

ectopic pregnancy?

A. So a probable ectopic pregnancy would mean that I am seeing something outside of the uterus that I am suspicious is ectopic, but I don't see characteristics that absolutely confirm that that is a pregnancy that I'm seeing versus some other structure such as an ovarian cyst that's complex.

Q. And what would your differential diagnosis -- what would you do with that patient, that Category 4?

(Knock at door)

Q. You can continue. You can continue. I'm listening.

MR. BOYLE: Thanks.

THE WITNESS: Differential diagnosis and treatment are two very different things. Would you like me to answer what the differential diagnosis was or what I would do for it?

Q. (Mr. Boyle) Start with the differential, yes.

A. So the differential diagnosis of a probable ectopic pregnancy is would be that there is an ectopic pregnancy that I can't definitely diagnosis or that there is some other structure outside of the uterus that I -- that could be a complex ovarian cyst, it

their gynecologist or an emergency room so that she can get worked up further, and they can rule it out or rule it in. Is that fair?

MS. SWANSON: Objection to form.

THE WITNESS: If a patient has a definite or probable ectopic pregnancy, that means that I am concerned about a potentially life-threatening condition, and I would refer them for further immediate evaluation.

Q. (Mr. Boyle) A patient with the fifth category, pregnancy of unknown location, could that be an ectopic pregnancy?

A. It could be.

Q. Are you suspicious that it might be an ectopic pregnancy?

MS. SWANSON: Objection to form.

THE WITNESS: No. If I'm suspicious that it might be an ectopic pregnancy, then I would consider it a probable or definite ectopic pregnancy.

Q. (Mr. Boyle) So if you have a pregnancy of unknown location on an ultrasound, you're not seeing an actual pregnancy or possible pregnancy either in the uterus or outside the uterus, correct?

A. Correct.

Q. Doesn't that raise your suspicion that that

patient could have an ectopic pregnancy, because you haven't ruled it out?

MS. SWANSON: Objection to form.

THE WITNESS: When I have a patient who has a probable -- or, pardon me, who has a pregnancy of unknown location, I consider three -- the most common three possibilities in my differential diagnosis: that they have an early intrauterine pregnancy that is not yet visible; that they have an early intrauterine pregnancy that is undergoing miscarriage; or that they have an ectopic pregnancy that is not yet visible.

Q. (Mr. Boyle) So when you have a Category 5, pregnancy of unknown location, on an ultrasound, part of your differential diagnosis is Number 3, that they may have an ectopic pregnancy that you just can't see yet?

A. That is correct. That is part of the differential diagnosis.

Q. Unless they are discovered and treated early, you would agree that almost 40 percent of ectopic pregnancies rupture suddenly, causing pain and bleeding in the abdominal cavity, wouldn't you?

A. I do not have that data.

Q. You don't know that data?

A. I do not know that statistic off the top of

my head.

Q. You would agree, at least, that ruptured ectopic pregnancies can be fatal, wouldn't you?

A. I would agree.

Q. At least 2 percent of pregnancies are ectopic pregnancies. Isn't that right?

A. The categorization I have heard is that up to 2 percent of pregnancies are ectopic pregnancies.

Q. We were talking about ACOG before. Are you familiar with ACOG Practice Bulletin 193?

A. I would have to look at it to know.

Q. You don't know it just off the top of your head?

A. Not from a number.

Q. Okay.

MR. BOYLE: I'm going to hand you a document.

MS. SWANSON: Thank you.

MR. BOYLE: You're welcome.

Q. (Mr. Boyle) Take your time, review that please, and let me know when you're ready to identify it.

A. I have not read it in detail, but I am -- I do have it in front of me.

Q. Okay. Are you able to identify what this is,

Q. Okay. If you look over that Risk Factor section on the first page, I'm going to read you a sentence and ask you about that. First sentence says, quote, "One-half of all women who receive a diagnosis of an ectopic pregnancy do not have any known risk factors," end quote. Do you see that?

A. I do see that.

Q. So you would agree that it's possible that a woman who comes into a PPSAT clinic has an ectopic pregnancy but doesn't have any known risk factors for that ectopic pregnancy?

A. Yes, that is possible.

Q. And the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus seen in the uterus. Isn't that right?

A. I don't know ---

MS. SWANSON: Object to form.

THE WITNESS: --- what you mean by, "gold standard."

Q. (Mr. Boyle) You don't use the word -- the term "gold standard" in your medical practice?

A. I would not use the term "gold standard" in this context.

Q. Do you use it in any context in your medical

practice?

MS. SWANSON: Objection to form.

THE WITNESS: I don't know that I -- it's not a -- it's not a term that I routinely use, no. I would say that ultrasound is a critical factor in diagnosis of ectopic pregnancy.

Q. (Mr. Boyle) I will accept that. If you turn to the second page of this Bulletin 193, under Clinical Considerations and Recommendations, How is an Ectopic Pregnancy Diagnosed; you see that section?

A. I do see that section.

Q. Okay. You see the sentence that says, quote, "The minimum diagnostic evaluation of a suspected ectopic pregnancy is transvaginal ultrasound evaluation and confirmation of pregnancy," end quote. Do you see that?

A. I do.

Q. So ACOG requires, according to this Bulletin, that in order to rule in or rule out an ectopic pregnancy, you have to have an ultrasound that shows the pregnancy. Is that correct?

A. That ---

MS. SWANSON: Objection to form.

THE WITNESS: That's not actually what it's saying. What it's saying is that the minimum

diagnostic evaluation, so the minimum you must do if you suspect ectopic pregnancy, is a transvaginal ultrasound evaluation.

And when they say, "and confirmation of pregnancy," they mean that if you do a transvaginal ultrasound but you haven't done another test to confirm that the patient is pregnant, such as a urine or blood pregnancy test, then it's not as useful.

For example, if a patient had a negative pregnancy test, then the -- the transvaginal ultrasound wouldn't be helpful. So if you do a transvaginal ultrasound and don't see a pregnancy, you would next do a pregnancy test to see if the patient was even pregnant.

Q. (Mr. Boyle) So you think that sentence there, that's talking clearly about ultrasound, means that a doctor doesn't have to actually confirm the pregnancy with the ultrasound? That's how you interpret that sentence?

MS. SWANSON: Objection to form.

THE WITNESS: No. What I am saying is that this sentence says that you must do an ultrasound, and you must also confirm that the patient is pregnant. Because often, for example, in pregnancy of unknown location, you will do an ultrasound and not see a

over, Serum Human CH -- CG -- HCG, sorry. Serum HCG Measurements, do you see that?

A. I see that.

Q. It says, quote, "Measurement of the Serum HCG levels aids in the diagnosis of women at risk of ectopic pregnancy. However, Serum HCG values alone should not be used to diagnosis an ectopic pregnancy and should be correlated with the patient's history, symptoms, and the ultrasound findings," end quote.

Do you see that?

A. I see that.

Q. So doesn't that say that you have to see an ectopic pregnancy by an ultrasound, either saying it's intrauterine or it's not?

MS. SWANSON: Objection to form.

THE WITNESS: No, that's not at all what it says.

Q. (Mr. Boyle) Okay. If you have a woman who has tested pregnant -- tested positive for pregnancy, and you take an ultrasound of her and you don't see a fetus or an embryo anywhere on that ultrasound, doesn't that actually raise your suspicion for her having an ectopic pregnancy on that differential diagnosis you were discussing earlier?

A. Yes, it does increase my suspicion for

ectopic pregnancy if I do not see a pregnancy either inside or outside of the uterus, including a gestational sac, not just a fetus or embryo.

Q. Okay. When you're treating a -- a woman who's tested positive for pregnancy, but she has a confirmed ectopic pregnancy, you don't provide her with the two chemical abortion drugs, do you?

A. That is correct. We do not treat anyone with a confirmed ectopic pregnancy with medication abortion medications.

Q. Because mifeprex (sic) and misoprostol are drugs that do not assist a woman in treating her for her ectopic pregnancy, are they?

MS. SWANSON: Object to form.

THE WITNESS: Mifepristone and misoprostol, as used in medication abortion, are not effective in treating ectopic pregnancy.

Q. (Mr. Boyle) And the FDA label says that they are contraindicated in patients with confirmed or suspected ectopic pregnancies, doesn't it?

A. I don't know what the FDA label says without looking at it.

Q. You've prescribed these medications several times every week for the past 14 years, correct?

A. That is correct.

Q. And you are unaware that the FDA label says that they are contraindicated for a woman who has an actual diagnosed or suspected ectopic pregnancy?

MS. SWANSON: Object to form.

THE WITNESS: I cannot directly quote the FDA label without looking at it. I am aware that we do not use mifepristone and misoprostol, as designed for medication abortion, in patients with known or suspected ectopic pregnancy.

Q. (Mr. Boyle) A patient who has a suspected ectopic pregnancy needs to be worked up to see if she needs surgical treatment for her ectopic pregnancy or if she qualifies for a different drug treatment, methotrexate, right?

A. There are different treatments for ectopic pregnancy, and those treatments should be offered based on the patient's exact circumstances, yes.

Q. Typically, the drug you give for ectopic pregnancy is methotrexate, not the two chemical abortion drugs, right?

A. I do not treat ectopic pregnancy, but it is -- you do not use mifepristone and misoprostol to treat ectopic pregnancy. Methotrexate is one of the medications that can be used to treat ectopic pregnancy.

Q. If you give a woman who tests positive for pregnancy, who is actually suffering from an ectopic pregnancy, the chemical abortion drugs, and it does not stop her ectopic pregnancy from growing, that ectopic pregnancy can rupture, possibly in her fallopian tubes or some other internal structure, causing damage and bleeding inside her abdomen. Isn't that right?

MS. SWANSON: Object to form.

THE WITNESS: Any woman who has an ectopic pregnancy, that ectopic pregnancy can rupture if it is not treated, regardless of whether the patient receives mifepristone and misoprostol or not.

Q. (Mr. Boyle) That's fair. But the prescription of those two drugs wouldn't have any impact on whether that ectopic pregnancy will continue to grow and possibly rupture, right?

A. I don't believe it's been extensively studied, but we do not treat ectopic pregnancy with mifepristone and misoprostol. There's a possibility that they could stop the growth theoretically, but we do not use it for that purpose.

Q. Okay. I appreciate that there may be further research to be done, but there's none that you're aware of that has been done to suggest that's an appropriate treatment regimen for ectopic pregnancy. Is that

correct?

MS. SWANSON: Object to form.

THE WITNESS: I am unaware that anyone would use mifepristone and misoprostol to treat a known or suspected ectopic pregnancy.

Q. (Mr. Boyle) You agree that many of the symptoms of a ruptured ectopic pregnancy mimic, or are exactly the same as, the expected side effects of a chemical abortion that you or one of your colleagues at PPSAT have counseled your patient could occur if you give that patient a chemical abortion, right?

MS. SWANSON: Object to form.

THE WITNESS: There are some overlapping symptoms between the normal symptoms we expect with medication abortion and the symptoms of an ectopic pregnancy.

Q. (Mr. Boyle) It's possible that a patient who took chemical abortion drugs and then suffered a ruptured ectopic pregnancy, leading to internal bleeding and vaginal bleeding, pain, dizziness, headache, could misconstrue or confuse those symptoms of the ectopic pregnancy with the normal expected side effects of the chemical abortion, as it was described to her by her doctor or other provider at PPSAT. Isn't that true?

MS. SWANSON: Object to form.

THE WITNESS: It would be important to educate any patient on whom we have not diagnosed an intrauterine pregnancy, who takes mifepristone and misoprostol, on the normal symptoms that they would experience with a medication abortion and on the abnormal symptoms that they might experience, including detailed education on the symptoms of ectopic pregnancy.

Q. (Mr. Boyle) But they might confuse a ruptured ectopic pregnancy for the normal side effects from the chemical abortion process, correct?

MS. SWANSON: Object to form.

THE WITNESS: I can't speculate on who might get confused by what. It is important to give clear education and closely follow up with patients.

Q. (Mr. Boyle) If you look at the document, please, at, let's see, Bates 31, on the first page there.

MS. SWANSON: And for the record, we're now switching back to the patient education packet from the ACOG bulletin.

Q. (Mr. Boyle) Right. Bates 31. Do you see that?

A. I see that form, yes.

treated as a transient state. An effort should be made to establish a definitive diagnosis when possible," end quote.

Do you see that?

A. I see that statement.

Q. So does that inform your opinions about what was going on back in 2018, as it relates to how to diagnosis and treat a patient with -- or ultrasound of pregnancy of unknown location?

MS. SWANSON: Object to form.

THE WITNESS: I would state that it is true now that we should make efforts to establish a definitive diagnosis when possible. We are just not required to make those efforts in isolation.

Q. (Mr. Boyle) And I did not mean to interrupt you in your review of -- I apologize, I did interrupt you. I'm sorry.

You were looking at Bates Number 102, Bates Number 103 and Bates Number 104 to tell us if there was any recent research identified by PPSAT that would support its position that it is acceptable medical practice to provide chemical abortion drugs simultaneous with a patient who has a diagnosis or a transient state of pregnancy of unknown location on an ultrasound.

MS. SWANSON: Object to form. I'm not sure there's a question in there.

Q. (Mr. Boyle) The question is: show it to me, please.

MS. SWANSON: Object to form.

THE WITNESS: So I do not see some of the articles that I know are used to create those protocols. I also don't think that the list of table references are the sole source of the protocols.

Q. (Mr. Boyle) And that's fine. I was just basing that off of what I understood you to say, that they were. If you're saying they're not, then there may be other things out there that go into the protocols. Is that what you're saying?

Maybe other research out there -- I apologize, maybe other research out there that goes into making these protocols that's not included at the end in that table?

A. There is much research and expert analysis that goes into making these. I do not personally create these protocols, so cannot speak to all of the details.

Q. You would agree that induced abortions, surgical abortions, become more complicated after the gestational age is beyond 14 weeks, wouldn't you?

MS. SWANSON: Object to form.

THE WITNESS: The complexity of a procedural abortion varies throughout gestational duration. And over seven or eight weeks, I would say that there is an incremental increase in complexity of the procedure with increasing gestational duration.

Q. (Mr. Boyle) You cited the "Academies of Medicine" article, and it says that "The risk of serious complication increases with weeks gestation; as the number of weeks increase, the invasiveness of required procedure and the need for deeper levels of sedation also increase."

Do you agree with that?

MS. SWANSON: Object to form.

THE WITNESS: I can't agree that that's the exact quote without looking at the actual document. I do agree that there is an incremental increase in risk as gestational duration increases.

Q. (Mr. Boyle) I'm sorry, I'm working through here.

You agree that some second trimester induced abortions must take place in a hospital setting, don't you?

MS. SWANSON: Object to form.

THE WITNESS: I would agree that some

abortions, regardless of gestational duration, must take place in a hospital.

Q. (Mr. Boyle) You would agree that anything beyond moderate sedation -- I think we've discussed it. But anything beyond moderate sedation anesthesia level for a surgical abortion must happen in a hospital, not at a PPSAT clinic, right?

MS. SWANSON: Object to form.

THE WITNESS: No, I would not agree to that. Deep sedation can be offered in an outpatient setting if you have the right equipment and staff. PPSAT does not have the staff to perform deep sedation in our outpatient clinics, but that doesn't preclude the safety of performing it in a clinic that has that staff.

Q. (Mr. Boyle) If a patient comes to PPSAT and has an ultrasound, and it's an ultrasound of unknown -- pregnancy of unknown location, do you charge for an additional -- does PPSAT charge for an additional ultrasound if that patient gets an additional ultrasound?

MS. SWANSON: Object to form.

THE WITNESS: Do you mean that if the patient had an ultrasound at an outside location that showed a pregnancy of an unknown location, and then we

performed an ultrasound, would we charge the patient for the ultrasound we performed?

Q. (Mr. Boyle) I didn't mean that, but do you?

A. If we perform an ultrasound, yes, we charge them for ---

Q. And if ---

A. --- the ultrasound performed.

Q. I'm sorry. If you come up with an ultrasound of pregnancy of unknown location and you take another one at PPSAT, do you charge for the second one also?

A. We do not routinely charge for repeat ultrasounds that we feel are clinically necessary, no.

Q. So if you charge for an ultrasound and the patient gets a second or even a third, you don't charge for the second or the third. Is that correct?

A. It is my understanding that we do not routinely charge for repeat ultrasounds that we deem clinically necessary.

Q. Have you ever had a situation where you had a patient with ultrasound finding of pregnancy of unknown location, you gave that patient chemical abortion drugs and then later, you determined that that patient had an ectopic pregnancy?

A. Yes, that has occurred.

Q. Did you give that patient a refund for the

unnecessary procedure that you performed?

MS. SWANSON: Object to form.

THE WITNESS: The patient is charged for the services they receive on the day they receive them, so the patient paid for the services they received, which included medications that they took.

Q. (Mr. Boyle) And you would agree that in that circumstance, the medications that the patient paid for were unnecessary, right?

MS. SWANSON: Object to form.

THE WITNESS: At the time that the medications were given, we did not know that they were unnecessary, so they were given in good faith.

Q. (Mr. Boyle) Absolutely. But had you waited, eventually you were able to determine that that particular patient had an ectopic pregnancy, right?

A. If it had been the patient's preference to wait, we certainly could have waited and not done the medication abortion yet.

Q. Well, you also could have just waited because you don't know where the pregnancy is, regardless of the patient's preference, right?

MS. SWANSON: Object to ---

Q. (Mr. Boyle) That's at least an option?

MS. SWANSON: Object to form.